

***IMS HEALTH v. AYOTTE:***  
**THE FIRST AMENDMENT AND**  
**PRESCRIBER-IDENTIFIABLE DATA**

By  
Donald B. Ayer  
*Jones Day*



**Washington Legal Foundation**  
**Critical Legal Issues**  
**WORKING PAPER SERIES No. 151**  
**October 2007**

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## ABOUT THE AUTHOR

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Mr. Ayer currently serves as an adjunct professor teaching a course in Supreme Court Litigation at Georgetown Law School, and, with two colleagues, conducting a Supreme Court litigation clinic at NYU Law School. He is listed in the *Best Lawyers in America* (2007), and is a member of American Academy of Appellate Lawyers, the American Law Institute, the American Bar Foundation, the Publications Committee of the Supreme Court Historical Society, the Advisory Boards of the Supreme Court Institute (Georgetown University); the Institute for Judicial Administration (NYU); and the State and Local Legal Center.

Before entering private practice in 1990, Mr. Ayer spent approximately ten years in the United States Department of Justice, including two Presidential appointments. He worked in California first as an Assistant United States Attorney, and from 1981-1986 as United States Attorney in Sacramento. In 1986, he moved to Washington as Principal Deputy Solicitor General under Solicitor General Charles Fried, during the final three years of the Reagan Administration. In 1989, after briefly joining Jones Day, he was appointed by President George H.W. Bush to serve as Deputy Attorney General during 1989-1990.

Mr. Ayer was counsel for Wolters Kluwer Health, Inc. and filed a brief *amicus curiae* with the district court in *IMS Health Inc. v. Ayotte*, 490 F. Supp. 2d 163 (D.N.H. 2007). He is presently counsel of record for *amicus curiae* Wolters Kluwer Health, Inc. in the appeal of that case docketed before the First Circuit as No. 07-1945.

The author wishes to acknowledge the major contributions to the drafting of this WORKING PAPER by Jones Day colleagues **Donald Earl Childress III** and **Sheerin N. Shahinpoor**.

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Pharmaceutical companies rely extensively on prescription-transaction information in developing prescription-drug marketing strategies directed toward physicians.<sup>1</sup> This medical data is assembled and cross-referenced by private companies who acquire it in raw form mainly from pharmacies and sell it to pharmaceutical companies and other users for commercial and non-commercial purposes.<sup>2</sup> This information, often called “prescriber-identifiable data,” matches the prescription to the prescribing physician, including his or her address, specialty, and other professional information, but excludes patient-identifiable information due to longstanding patient privacy protections in federal and state law.<sup>3</sup> Pharmaceutical companies have used this prescriber-identifiable data in many ways, including: (1) targeting leaders in the medical field for approval and use of new prescription drugs and (2) through sales efforts called “physician detailing.”

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<sup>1</sup>*IMS Health Inc. v. Ayotte*, 490 F. Supp. 2d 163, 165 (D.N.H. 2007).

<sup>2</sup>For instance, such data is often made available at little or no cost to academic researchers, medical researchers, humanitarian organizations, and law enforcement authorities. These entities use the information to track disease patterns and treatment, conduct research and clinical trials, and engage in economic analyses. *Id.* at 166 n.2.

<sup>3</sup>*Id.*; see also Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. pts. 164.302-.534 (2003) (setting privacy standard for every patient whose information is collected, used, or disclosed by covered entities).

Many state legislatures have considered adopting laws regulating such practices, driven by concerns that the use of prescriber-identifiable data, coupled with other pharmaceutical sales tactics, invades physician and patient privacy and creates undue pressure for physicians to prescribe brand-name drugs.<sup>4</sup> This WORKING PAPER provides an overview of current state action in this area and briefly details the First Amendment implications of state regulations on prescriber-identifiable data.

## I. THE NEW HAMPSHIRE PLAN

On June 30, 2006, New Hampshire became the first state to enact a law—the Prescription Information Law (PIL)—prohibiting the use of prescriber-identifiable data for certain commercial purposes, namely the marketing practices used by most pharmaceutical companies.<sup>5</sup> IMS Health Inc. (IMS) and Verispan, two companies engaged in the assembly and sale of medical data, filed a complaint on July 26, 2006 in the United States District Court for the District of New Hampshire, challenging the PIL’s constitutionality.<sup>6</sup>

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<sup>4</sup>Since 2001, fifteen states (Illinois, Minnesota, North Dakota, Kentucky, Wisconsin, New Jersey, South Carolina, Nevada, Arizona, West Virginia, Nebraska, California, Massachusetts, New York, and Hawaii) have introduced but not passed legislation restricting prescriber-identifiable data; one state (Maine) has amended its statutes to allow doctors to voluntarily petition to keep their data from being disclosed; and two states (New Hampshire and Vermont) have passed new legislation prohibiting the use of such data for certain commercial and marketing purposes. In addition to New Hampshire’s statute, the Maine and Vermont statutes will be discussed *infra* at 8-16.

<sup>5</sup>The relevant portion of the statute states: “Records relative to prescription information containing . . . prescriber-identifiable data shall not be licensed, transferred, used, or sold . . . for any commercial purpose . . . [which] include[s], but is not limited to, advertising, marketing, promotion, or any activity that could be used to influence sales or market share of pharmaceutical products, influence or evaluate the prescribing behavior of an individual health care professional, or evaluate the effectiveness of a professional pharmaceutical detailing sales force.” See N.H. REV. STAT. ANN. §§ 318:47-f, B:12.

<sup>6</sup>Pl.’s Compl.

Specifically, the companies argued that the PIL restricted non-commercial speech and was subject to strict scrutiny, which is the highest protection granted to speech.<sup>7</sup> Alternatively, they argued that the PIL restricted commercial speech without satisfying the lower intermediate-scrutiny standard thus applicable.<sup>8</sup> The State responded by arguing that the PIL did not implicate protected speech, because it targeted factual information (prescriber-identifiable data), which should not be viewed as speech at all, and because the PIL regulated the “uses” of prescriber-identifiable information rather than the disclosure of such information.<sup>9</sup> Alternatively, the State argued that, if a speech restriction, the PIL regulated commercial speech in a manner consistent with the intermediate-scrutiny standard.<sup>10</sup>

On April 30, 2007, after a two-week trial in Federal District Court in New Hampshire, Judge Paul J. Barbadoro issued a thorough and carefully reasoned opinion holding that the PIL was unconstitutional. First, the court dismissed the State’s arguments that the PIL did not implicate protected speech at all, finding, under well-established Supreme Court precedent, that speech involving factual information, rather than viewpoints, is still subject to First Amendment protection.<sup>11</sup> Likewise, the court found that the law is “a speech restriction because it limits both the use and disclosure of prescriber-identifiable data for

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<sup>7</sup>See *id.* ¶¶ 56-57; see also *IMS Health Inc.*, 490 F. Supp. 2d at 173 (recognizing a compelling governmental purpose as an interest of the highest order).

<sup>8</sup>See Pl.’s Compl. ¶ 65; see also *Central Hudson Gas & Elec. Corp. v. Public Serv. Comm’n of New York*, 447 U.S. 557, 564 (1980) (setting forth the test for regulating truthful commercial speech as requiring the regulation directly advance a substantial government interest and be no more extensive than necessary to serve its purpose).

<sup>9</sup>See Def’s Mem. Supp. Objection to Pl.’s Mot. for Prelim. Inj. § III.A.1; see also *IMS Health Inc.*, 490 F. Supp. 2d at 174-75.

<sup>10</sup>*IMS Health Inc.*, 490 F. Supp. 2d at 174-75.

<sup>11</sup>See *id.* at 175.

commercial purposes.”<sup>12</sup> Because the PIL, by its terms, restricted the use of prescriber-identifiable data only “for any commercial purpose” and affected commercial transactions between pharmaceutical companies and physicians, Judge Barbadoro applied the Supreme Court’s commercial speech jurisprudence, under which the State is required to demonstrate that the statute “directly advance[d]” a “substantial [state] interest” and is “not more extensive than necessary to further the state’s interest.”<sup>13</sup>

The State argued that the PIL served three substantial purposes: protecting patient and physician privacy, promoting public health, and containing healthcare costs.<sup>14</sup> Judge Barbadoro rejected the State’s physician privacy argument, which asserted that the manner in which pharmaceutical companies use prescriber-identifiable data negatively affects physicians’ prescribing decisions through undue pressure and harassment, ultimately eroding doctor-patient trust. First, the court found that the State did not provide any evidence that pharmaceutical companies used the data to “improperly coerce or harass [physicians].”<sup>15</sup> Second, the State relied on privacy case law that Judge Barbadoro found inapposite, because “[this] case does not involve [commercial] solicitations that invade the tranquility of the home or that targets vulnerable victims.”<sup>16</sup> Finally, the State provided no indication that the negative impact on the doctor-patient relationship affected patient privacy. Thus, Judge Barbadoro rejected the physician privacy

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<sup>12</sup>*Id.*

<sup>13</sup>*See Central Hudson*, 447 U.S. at 564, 569.

<sup>14</sup>*See* Def’s Mem. Supp. Objection to Pl.’s Mot. for Prelim. Inj. § III.A.2.

<sup>15</sup>*IMS Health Inc.*, 490 F. Supp. 2d at 175.

<sup>16</sup>*See id.* at 179.

argument and concluded that the State’s privacy assertions concerned the consequences of how the prescriber data affected physicians’ prescribing decisions, and thus simply restated the State’s public health and cost-containment arguments.<sup>17</sup>

Judge Barbadoro also found that the State’s arguments relating to public health and cost-containment were sufficiently substantial to meet the first prong of the *Central Hudson* test, but went on to find that the PIL did not directly advance those interrelated interests. The court found that the State had relied on the faulty reasoning that prescribing more branded drugs would increase health-care costs and undermine public health, which “depends on the counterintuitive and unproven proposition that . . . brand-name drugs are more injurious to public health than generic alternatives.”<sup>18</sup> Moreover, the State failed to consider the positive impact that detailing could have by introducing certain drugs, and it provided insufficient evidence to show cost reductions would result from banning the use of prescriber-identifiable data.<sup>19</sup> The court concluded that even if the State’s assumptions were true, New Hampshire “does not have a substantial interest in shielding physicians from sales techniques that enhance the effectiveness of truthful and non-misleading market information.”<sup>20</sup>

Finally, even assuming the PIL directly advanced the State’s substantial interests in public health and cost-containment, Judge Barbadoro found that

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<sup>17</sup>*Id.* (noting that the State’s privacy claims are “nothing more than a restatement of [its] contentions that the law can be justified because it prevents pharmaceutical companies from using prescriber-identifiable data in ways that undermine public health and increase health care costs”).

<sup>18</sup>*Id.*

<sup>19</sup>*Id.*

<sup>20</sup>*Id.* at 181.

the PIL was more extensive than necessary to meet the State’s objectives.<sup>21</sup> First, the PIL encompassed conduct—providing physicians with important and timely information—that would advance the State’s objectives.<sup>22</sup> Second, there were several alternatives by which the State could address possible negative impacts of detailing without a broad ban on sharing information embodied in the PIL.<sup>23</sup> First, the State could directly target objectionable marketing tactics by limiting pharmaceutical companies’ use of meals, gifts, and other inducements, an approach recently adopted in Minnesota.<sup>24</sup> Second, the legislature could require the State to prepare and distribute “competing information that will help health care providers balance and place in context the sales messages that detailers deliver,” “develop counter-detailing programs that make health care providers aware of the cost-implications of their prescribing decisions,” or require physicians “to regularly participate in continuing medical education programs . . . specifically designed to provide practitioners with the best available information concerning the advantages and disadvantages of prescribing generic . . . rather than brand-name drugs.”<sup>25</sup> Third, the State could directly address concerns that pharmaceutical companies are using prescriber-identifiable data to drive up Medicaid costs by implementing a program requiring prior authorization to prescribe certain medications, and thus “prevent unnecessary expenditures on brand-name drugs . . . when not medically necessary.”<sup>26</sup>

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<sup>21</sup>*Id.* at 181-83.

<sup>22</sup>*Id.* at 181.

<sup>23</sup>*Id.* at 181-83.

<sup>24</sup>*Id.*; *see also* MINN. STAT. ANN. § 151.461 (2007).

<sup>25</sup>*IMS Health Inc.*, 490 F. Supp. 2d at 182.

<sup>26</sup>*Id.*

In light of these findings, the court invalidated the PIL under the First Amendment. Although the State had proffered two sufficiently substantial government interests in favor of restricting prescriber-identifiable data—cost containment and promoting public health—the PIL did not directly advance those interests; in fact, it perhaps hindered their achievement. Moreover, because there were several less-burdensome alternatives by which the State could serve those interests, the PIL was more extensive than necessary.

Judge Barbadoro’s analysis appears to be a careful application of the Supreme Court’s First Amendment jurisprudence. Because the PIL restricts the use of prescriber-identifiable data for “any commercial purpose” and, as Judge Barbadoro found, affected commercial transactions between pharmaceutical companies and physicians, it implicates protected commercial speech and is subject to the protections of the First Amendment. Its validity is governed, as Judge Barbadoro held, by the *Central Hudson* three-factor test applicable to commercial speech: (1) the state’s interest must be substantial, (2) the law must directly advance the interest, and (3) the law cannot be more extensive than necessary for the state to meet its objectives.<sup>27</sup>

The court first found, correctly, it appears, that, while New Hampshire has a substantial interest in cost-containment and promoting public health, the PIL’s restriction on the use of prescriber-identifiable data does not directly advance cost-containment or promote public health, because discouraging doctors from prescribing brand-name drugs could both increase healthcare costs and detrimentally affect public health. Additionally, even if the statute did advance the objectives, the court found the law to be more restrictive than necessary, because several feasible alternatives exist by which the state could achieve its goals without restricting protected commercial speech. The court

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<sup>27</sup>See *Central Hudson*, 447 U.S. at 561.

thus correctly found the statute unconstitutional on two distinct and independent grounds.

## II. VERMONT “OPTS OUT”

On June 9, 2007, shortly after Judge Barbadoro’s decision, Vermont enacted a law restricting the commercial use of prescriber-identifiable data.<sup>28</sup> Although the law was functionally similar to the PIL, there are several key differences in the statute, some of which are intended to address the constitutional deficiencies identified in the New Hampshire case.

Seemingly to address the concern that the legislature demonstrate that the statute really remedies a problem of excessive prescription costs and/or protects the public health, the Vermont statute includes thirty-one findings made by the General Assembly. These findings state that pharmaceutical companies’ marketing goals are “designed to increase sales, income, and profit,” which “frequently” conflict with the State’s interests in curtailing excessive prescription costs and promoting public health.<sup>29</sup> The findings also indicate that the pharmaceutical industry spent “[twenty-seven billion dollars in 2004]

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<sup>28</sup>The statute’s key language states: “[T]o advance the state’s interest in protecting the public health of Vermonters, protecting the privacy of prescribers and prescribing information, and to ensure costs are contained in the private health care sector . . . through the promotion of less costly drugs and ensuring prescribers receive unbiased information . . . . prescription information containing prescriber-identifiable data [can be] used for marketing or promoting a prescription drug only if: (1)(A) a prescriber has provided consent for the use of that data . . . and (1)(B) the entity using the regulated records complies with the [state’s] disclosure requirements.” 18 V.S.A. § 4631 (2007). Rather than banning uses and transfers of prescriber-identifiable data for “commercial purpose[s],” *see* N.H. REV. STAT. ANN. §§ 318:47-f, B:12, Vermont’s statute bans all “use[s]” of such information for “marketing” or “promoting a prescription,” which are defined as basically any activity that might “influence sales” or “advertise or publicize a prescription drug,” *see* 18 VSA § 4631(b).

<sup>29</sup>An Act Relating to Increasing Transparency of Prescription Drug Pricing and Information, S. 115, Vt. Gen. Assembly, § 1 (2007) (enacted).

marketing pharmaceuticals in the United States,” “increased its spending on direct marketing to doctors by 275% [coincident with the rise in data mining],” and “doubled its sales force” to include an estimated “one representative for every five office-based physicians.”<sup>30</sup> Further, the findings assert, pharmaceutical companies are increasing their use of prescriber-identifiable data in marketing to “track the prescribing habits of nearly every physician in Vermont and link those habits to specific physicians and their identities,” which not only “intrudes into the way physicians practice medicine,” but also increases the companies’ ability to influence physicians’ prescribing practices.<sup>31</sup>

While noting that Vermont “has been a leader in prescription drug cost-containment” through several enumerated means,<sup>32</sup> the statute notes that the State cannot compete with pharmaceutical companies’ resources and effective marketing tactics.<sup>33</sup> Moreover, according to the findings, physicians have limited time to “research the quickly changing pharmaceutical market and determine which drugs are the best treatments for particular conditions” and necessarily rely on pharmaceutical companies, which operate in a “frequently one-sided” market driven by “brand-name companies invest[ing] in expensive . . . marketing campaigns.”<sup>34</sup> The findings explain that because pharmaceutical companies have a biased focus on newer drugs that do not “necessarily provide additional benefits over older drugs, but do add costs and . . . unknown side-

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<sup>30</sup>*Id.*

<sup>31</sup>*Id.*

<sup>32</sup>These enumerated means include “mandatory generic substitution,” encouraging “a preferred drug list in the state employees” Medicaid plans, “providing consumers with pricing information about the drugs they are prescribed,” and “requiring [pharmaceutical companies] to disclose . . . drug pricing information to doctors.” *Id.*

<sup>33</sup>*Id.*

<sup>34</sup>*Id.*

effects,” it leads to “a massive [information] imbalance” within the prescription-drug market, which “ill serves” public health. Thus, the findings contend, physicians are making prescribing decisions based on “incomplete and biased information,” which not only increases state-wide health-care costs, but is detrimental for public health. For these reasons, the State asserts that it must intervene “to save money for the state, consumers, and businesses, by promoting the use of less expensive drugs” and to “protect public health” by requiring “evidence-based disclosures and promoting drugs with longer safety records.”<sup>35</sup>

The Vermont legislature also attempted to more narrowly tailor its restriction on speech. While the Vermont legislation does generally ban uses of prescriber-identifiable prescription information for “marketing” or “promoting a prescription,” which includes activities that might “influence sales” or “advertise or publicize a prescription drug,”<sup>36</sup> it allows an exception to this ban—and thus allows the information to be used—only if (1) the prescribing physician consents through the state and (2) the pharmaceutical company follows the state’s disclosure requirements.<sup>37</sup> Thus, according to the statute, when a physician consents to dissemination of his or her prescribing information, the pharmaceutical company may use the physician’s prescriber-identifiable data, but must disclose the following information to him or her: the “specific health benefits or risks of using other pharmaceutical drugs, including [over-the-counter drugs],” the “patients [who] would gain from the benefits or be susceptible to risks described,” and the availability and cost of “other

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<sup>35</sup>*Id.*

<sup>36</sup>18 V.S.A. § 4631(b).

<sup>37</sup>18 V.S.A. § 4631(f).

prescription treatment options.”<sup>38</sup> Thus, while New Hampshire sought to ban the commercial use of prescriber-identifiable data outright regardless of what the prescriber wants, Vermont’s statute allows the prescriber to have his or her information shared if he or she opts-out of the ban.

Notwithstanding the Vermont General Assembly’s additional findings and attempts to more narrowly tailor the restriction by creating an “opt-out” protocol for prescribers, the Vermont law still appears likely to fail a First Amendment challenge. Unless a physician consents, the Vermont law prohibits the use of prescriber-identifiable data “for marketing or promotion of a prescription drug”—one form of protected commercial speech.<sup>39</sup> To permissibly restrict the use of prescribing data, the state must, following *Central Hudson*, demonstrate (1) a substantial state interest exists, (2) the law directly advances the state’s interest, and (3) the law is not more extensive than necessary to achieve the objective.<sup>40</sup> The statute would likely fail under this test.

The Vermont General Assembly, like New Hampshire, asserts three core government interests in support of the law: cost-containment, promoting public health, and physician privacy. As Judge Barbadoro found, a claimed interest in physician privacy—unlike patient privacy—is likely not a substantial government interest. Thus, assuming that promoting public health and cost containment are substantial government interests, the next issue is whether the law directly advances these interests. Vermont’s claim that it does rests on an assertion that physicians necessarily rely on pharmaceutical companies’ one-

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<sup>38</sup>*Id.*

<sup>39</sup>This appears to be true whether one construes commercial speech broadly as speech relating “to the economic interests of the speaker and its audience,” *Central Hudson*, 447 U.S. at 561, or more narrowly, as speech that “proposes a commercial transaction,” *Bd. of Trustees of State University of N.Y. v. Fox*, 492 U.S. 469, 473-74 (1989).

<sup>40</sup>*Id.*

sided marketing to learn about new drugs, and are somehow compelled or misled into buying the newest, most expensive drugs, thus increasing overall healthcare costs and negatively affecting public health.<sup>41</sup>

So, the argument goes, the ban on the commercial use of prescriber-identifiable data to market brand-name drugs will decrease healthcare cost and promote public health by reducing the amount of information provided to physicians about often new, expensive, non-generic pharmaceutical products, and thus reducing purchase and use of those products.<sup>42</sup> A major problem with such reasoning is that, although Vermont's findings included evidence regarding the potentially negative impact of newer drugs, they do not include evidence regarding the health benefits of introducing newer drugs into the market.<sup>43</sup> Thus, the evidence does not suggest that restricting the use of non-consenting physicians' prescribing information would directly advance the State's interest in public health.

Similarly, although the findings did include evidence that the "five-fold" cost-increase in drug purchases over the past decade "can be attributed to marketing-induced shifts in doctors' prescribing from [less costly] therapies to new and more expensive treatments, there was scant evidence on the cost-consequences of not promoting such drugs, other than asserting that the newer drugs "often have little or no increased therapeutic value."<sup>44</sup> Impeding pharmaceutical companies' promotion of brand-name drugs may reduce certain healthcare costs, but that reduction is illusory if it is at the expense of lost

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<sup>41</sup>An Act Relating to Increasing Transparency of Prescription Drug Pricing and Information, S. 115, Vt. Gen. Assembly, § 1 (2007) (enacted).

<sup>42</sup>*Id.*

<sup>43</sup>*Id.*

<sup>44</sup>*Id.*

benefits of new drugs, which in turn lead to different, increased costs. Thus, it is unclear whether the Vermont law actually advances the State's interest in cost-containment.

The final *Central Hudson* inquiry asks if the speech restrictions are more extensive than necessary to meet the government's objectives. It thus poses the issue whether there are alternatives by which the state could achieve its objectives without any, or with lesser, restrictions protected speech. The Vermont law takes note of Judge Barbadoro's suggestion to address the problem by various measures not restrictive of speech, and itself requires, albeit in somewhat vague terms, a number of affirmative disclosures at the time promotional information is shared with a physician. Also, the Vermont law is not a complete restriction on the use of prescriber-identifiable data in the marketing and promotion of prescription drugs, because it includes an opt-out process for physicians to consent to the use of their prescribing data.

All of that said, it is quite likely that the Vermont law is invalid for the same reasons as the New Hampshire statute. The *Central Hudson* focus on less restrictive alternatives is for the purpose of avoiding outright or more extreme restrictions on speech. And here, while the statute's opt-out provision means that some collection of physicians will allow their information to be used, for those physicians who do not consent, the Vermont law serves as a complete restriction on the use of prescribing data. Without further evidence demonstrating that the existing, non-restrictive alternatives are ineffective, the law will likely be struck down as violating the First Amendment.

### **III. MAINE “OPTS IN”**

On June 29, 2007, the State of Maine amended its privacy statutes to address concerns raised by prescriber-identifiable data. As amended, the

Maine Prescription Privacy Law (effective January 1, 2008) creates procedures through which physicians may file for confidentiality protection of prescriber-identifiable information with the State.<sup>45</sup> In contrast to both New Hampshire and Vermont, the Maine statute thus includes a provision by which physicians may “opt-in” to the statute’s concealment of prescriber identifiable prescription data. Thus, a physician acts affirmatively to place his or her name on a list requesting confidentiality protection, and absent that, the information can be shared. Once this is done the “license, use, s[a]ll[e], transfer or exchange for value, for any marketing purpose” of such information is prohibited.<sup>46</sup> The prescriber would have this opportunity both at the time of his or her licensing, and through the internet at any time.<sup>47</sup>

Importantly, the Maine statute follows the AMA’s Prescribing Data Restriction Program,<sup>48</sup> which allows physicians in the United States, regardless of whether they are members of the AMA, to deny all pharmaceutical sales representatives access to their individual prescribing data. Accompanying this protocol, as in Vermont, were a series of legislative findings. These findings, while not as extensive as Vermont’s, largely duplicate the New Hampshire and Vermont arguments regarding physician privacy, improving public health, and cost containment.

Despite these modifications, the Maine law is probably still constitutionally deficient for the same reasons as the New Hampshire law. The state interests listed in the Maine statute are effectively the same interests used by the New Hampshire attorney general in defending New Hampshire’s version of the law. While invalidating the New Hampshire law, the Judge Barbadoro

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<sup>45</sup>§ 1.22 MRSA § 1711-E(f)(2(A)).

<sup>46</sup>*Id.*

<sup>47</sup>*Id.*

<sup>48</sup>Available at [www.ama-assn.org/ama/pub/category/12054.html](http://www.ama-assn.org/ama/pub/category/12054.html).

dismissed the interest in protecting provider privacy. He also found counterintuitive and unproven the general claim that public health is undermined when pharmaceutical sales people have more information to assist them in promoting their products. Moreover, the court listed several strategies to advance any legitimate interests that the state may have that are arguably narrower than prohibiting the transmission of prescriber-identifiable data, even if the prohibition has an opt-in provision. For the group of physicians who opt in to its suppression of accurate prescriber-linked information, the Maine law remains a state-sponsored, flat ban on free speech.

#### **IV. WHAT DOES THE FUTURE HOLD FOR PRESCRIBER-IDENTIFIABLE DATA?**

In light of Judge Barbadoro's careful application of *Central Hudson*, it is unlikely that either the Vermont or Maine statutes would survive scrutiny. Both purport to advance public purposes by governmental restrictions on dissemination of information, which in turn reduce the amount of information available to medical professionals. Such an approach runs counter to intuition and the spirit of the First Amendment. Even assuming that a trained physician is susceptible to being seriously misled by salespeople he or she chooses to let in to his or her office, it is hard to imagine that a reasonable counter strategy of ensuring the dissemination of information reflecting a different perspective would be ineffective. And beyond that, in a variety of ways, the State has power, should it choose to use it, to directly affect the prescribing decisions that a licensed physician makes. Without states having seriously tried these other avenues, it is hard to see how any state plan restricting the disclosure of prescriber-identifiable data can comport with the First Amendment.

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